SERFF Tracking Number:	*NYLC-127311493*	*State:*	*Arkansas*
Filing Company:	*New York Life Insurance Company*	*State Tracking Number:*	*49245*
Company Tracking Number:	*211-500, ET AL.*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*2011 NB21 Applications*		
Project Name/Number:	*2011 NB21 Applications /211-500, et al.*		

Filing at a Glance

Company: New York Life Insurance Company

Product Name: 2011 NB21 Applications	SERFF Tr Num: NYLC-127311493	State: Arkansas
TOI: L08 Life - Other	SERFF Status: Closed-Approved-Closed	State Tr Num: 49245
Sub-TOI: L08.000 Life - Other	Co Tr Num: 211-500, ET AL.	State Status: Approved-Closed
Filing Type: Form		Reviewer(s): Linda Bird
	Authors: Team Leader, Robert Williams III, Ariana Little	Disposition Date: 07/11/2011
	Date Submitted: 07/07/2011	Disposition Status: Approved-Closed
Implementation Date Requested: On Approval		Implementation Date:

State Filing Description:

General Information

Project Name: 2011 NB21 Applications	Status of Filing in Domicile:
Project Number: 211-500, et al.	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Individual
Submission Type: New Submission	Individual Market Type:
Overall Rate Impact:	Filing Status Changed: 07/11/2011
	State Status Changed: 07/11/2011
Deemer Date:	Created By: Ariana Little
Submitted By: Ariana Little	Corresponding Filing Tracking Number:

Filing Description:

Re: New York Life Insurance Company (NYLIC)
FEIN #: 13-5582869
NAIC: 826 66915
Individual Life Insurance Application Part I, Form 211-500, et al;

Dear Commissioner:

We are enclosing for your Department’s approval new application forms and related forms for use when applying for individual life insurance products. We are planning to introduce these new forms in November 2011 or as soon

thereafter as administratively possible.

The following forms are enclosed:

(1) a Part I application 211-500 to replace our Part I form 209-501 which was previously approved on 2/12/2009;
(2) a Medical Questionnaire (Non-Medical - Application Part II) form 211-510 to replace the Non-medical Part II form 209-510 which was previously approved on 10/23/2008;
(3) a Medical Examiner's Report – Application Part II, form 211-525, that will replace the Medical Examiner's Report – Part II, form 209-525 which was previously approved on 10/23/2008.

The enclosed forms are designed for use by New York Life Insurance Company and its two subsidiary companies, New York Life Insurance and Annuity Corporation and NYLIFE Insurance Company of Arizona. The forms will be filed for use by each of those companies under separate cover.

The Part I application is a general application form that will be used to apply for individual life insurance products. Like the application it replaces, this new application includes a blank space at the end of each Company's Plan area for temporary use when new products are introduced before the application form can be updated and a section that will be completed only if Additional Insureds are to be covered under the policy. Additional copies of these questions will be available to ensure that we obtain necessary information for all Additional Insureds proposed for coverage.

Differences Between the Enclosed New Form and the Application It Replaces

- The Plan section has been updated to include new products and riders that have been introduced since the previous application was approved.
- The Plan section has been updated to delete products and riders that are no longer being marketed.
- A field to capture email address has been added to the Primary Insured contact information, the Owner's contact information and Additional Insured's' contact information.
- A field to capture the date of birth, Social Security number and/or Tax ID number has been added to the Named Beneficiaries fields.
- Questions 5 and 7 in the Non-Medical Questionnaire and the Additional Insured Non-Medical Questionnaire have been revised.
- An Electronic Funds Transfer (EFT) option has been added (page 13 of this application).

Please note that this Part I Application form allows for the selection of the Asset Preserver policy, which is a universal life policy that allows for the acceleration of the death benefit for terminal illness and for chronic illness necessitating qualified long-term care service. Note that any underwriting questions or disclosures unique to that product appear in a separate supplement that was previously approved by your department.

SERFF Tracking Number:	*NYLC-127311493*	*State:*	*Arkansas*
Filing Company:	*New York Life Insurance Company*	*State Tracking Number:*	*49245*
Company Tracking Number:	*211-500, ET AL.*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*2011 NB21 Applications*		
Project Name/Number:	*2011 NB21 Applications /211-500, et al.*		

The enclosed Application is intended to fulfill multiple purposes. Because of that, it includes check boxes for reinstatements, term conversions, and amending the application, etc. There are questions in the term conversion section that are specific to the processing of term conversions for administrative purposes. Moreover, when additional coverage is applied for in conjunction with a term conversion, the entire application is completed for the additional insurance.

This application will be used in paper. The PDF submitted is the typeset version that will be printed by an outside vendor and stocked for use. It will also be made available on the company intranet for printing by the agents on their personal computers.

The Medical Questionnaire (Non-Medical – Application Part II) and the Medical Examiner's Report- Application Part II have been revised to conform to the revised questions 5 and 7 in the Part I application.

Replacement questions are included in a separate form "Important Notice: Replacement of Life Insurance or Annuities", form 22190.100 which was approved by your Department on 9/13/2007 under NYLIC DOI #36863;. Both the applicant and the agent must sign this form, and it is required that one copy be left with the applicant and another copy be submitted with every Part I application. A Part I application will not be processed without a signed Replacement form.

We would appreciate receiving your approval of the enclosed forms, at your earliest convenience. If there are any questions regarding this filing, you may call me toll free at 1-877-464-0198 or email me at Linda_E._LoPinto@newyorklife.com.

Sincerely,
Linda E. LoPinto
Corporate Vice President
US Life Insurance Administration

Company and Contact

Filing Contact Information

Robert Williams III, Contract Associate III	Robert_Williams_III@nyl.com
51 Madison Avenue	212-576-3449 [Phone]
Room 606	212-447-4141 [FAX]
New York, NY 10010	

Filing Company Information

New York Life Insurance Company	CoCode: 66915	State of Domicile: New York
51 Madison Avenue	Group Code: 826	Company Type: Life

SERFF Tracking Number:	*NYLC-127311493*	*State:*	*Arkansas*
Filing Company:	*New York Life Insurance Company*	*State Tracking Number:*	*49245*
Company Tracking Number:	*211-500, ET AL.*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*2011 NB21 Applications*		
Project Name/Number:	*2011 NB21 Applications /211-500, et al.*		

New York, NY 10010 Group Name: State ID Number:

(212) 576-4809 ext. [Phone] FEIN Number: 13-5582869

Filing Fees

Fee Required?	Yes
Fee Amount:	$60.00
Retaliatory?	No
Fee Explanation:	$20 per form.
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
New York Life Insurance Company	$60.00	07/07/2011	49520441
New York Life Insurance Company	$90.00	07/08/2011	49566761

SERFF Tracking Number:	*NYLC-127311493*	*State:*	*Arkansas*
Filing Company:	*New York Life Insurance Company*	*State Tracking Number:*	*49245*
Company Tracking Number:	*211-500, ET AL.*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*2011 NB21 Applications*		
Project Name/Number:	*2011 NB21 Applications /211-500, et al.*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	07/11/2011	07/11/2011

Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	**Created By**	**Created On**	**Date Submitted**	**Responded By**	**Created On**	**Date Submitted**
Pending Industry Response	Linda Bird	07/08/2011	07/08/2011	Ariana Little	07/08/2011	07/08/2011

SERFF Tracking Number:	*NYLC-127311493*	*State:*	*Arkansas*
Filing Company:	*New York Life Insurance Company*	*State Tracking Number:*	*49245*
Company Tracking Number:	*211-500, ET AL.*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*2011 NB21 Applications*		
Project Name/Number:	*2011 NB21 Applications /211-500, et al.*		

Disposition

Disposition Date: 07/11/2011
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*NYLC-127311493*	*State:*	*Arkansas*
Filing Company:	*New York Life Insurance Company*	*State Tracking Number:*	*49245*
Company Tracking Number:	*211-500, ET AL.*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*2011 NB21 Applications*		
Project Name/Number:	*2011 NB21 Applications /211-500, et al.*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		No
Form	Individual Life Insurance Application Part I		Yes
Form	Medical Questionnaire (Non-Medical – Application Part II)		Yes
Form	Medical Examiner's Report – Application Part II		Yes

SERFF Tracking Number:	*NYLC-127311493*	*State:*	*Arkansas*
Filing Company:	*New York Life Insurance Company*	*State Tracking Number:*	*49245*
Company Tracking Number:	*211-500, ET AL.*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*2011 NB21 Applications*		
Project Name/Number:	*2011 NB21 Applications /211-500, et al.*		

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	07/08/2011
Submitted Date	07/08/2011
Respond By Date	08/08/2011

Dear Robert Williams III,

This will acknowledge receipt of the captioned filing.

Objection 1
Comment: Regulation 57 was revised effective January 2010, the filing fee is now $50.00 per form. We will hold your filing in a pending status until the additional $90.00 is received.

Please feel free to contact me if you have questions.
Sincerely,
Linda Bird

SERFF Tracking Number:	*NYLC-127311493*	*State:*	*Arkansas*
Filing Company:	*New York Life Insurance Company*	*State Tracking Number:*	*49245*
Company Tracking Number:	*211-500, ET AL.*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*2011 NB21 Applications*		
Project Name/Number:	*2011 NB21 Applications /211-500, et al.*		

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	07/08/2011
Submitted Date	07/08/2011

Dear Linda Bird,

Comments:
Thank you for contacting us regarding this filing,

Response 1

Comments: Please note that the additional $90 has been remitted.

Related Objection 1

Comment:
Regulation 57 was revised effective January 2010, the filing fee is now $50.00 per form. We will hold your filing in a pending status until the additional $90.00 is received.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Sincerely,
Ariana Little

Sincerely,
Ariana Little, Robert Williams III, Team Leader

SERFF Tracking Number:	*NYLC-127311493*	*State:*	*Arkansas*
Filing Company:	*New York Life Insurance Company*	*State Tracking Number:*	*49245*
Company Tracking Number:	*211-500, ET AL.*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*2011 NB21 Applications*		
Project Name/Number:	*2011 NB21 Applications /211-500, et al.*		

Form Schedule

Lead Form Number: 211-500, et al.

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	211-500	Application/ Enrollment Form	Individual Life Insurance Application Part I	Revised	Replaced Form #: Previous Filing #:	51.000	80915-1 211-500.pdf
	211-510	Application/ Enrollment Form	Medical Questionnaire (Non-Medical – Application Part II)	Revised	Replaced Form #: Previous Filing #:	68.000	80954-0 NYL 211-510.pdf
	211-525	Application/ Enrollment Form	Medical Examiner's Report – Application Part II	Revised	Replaced Form #: Previous Filing #:	71.000	80955-0 NYL 211-525.pdf

PART 1 01

INDIVIDUAL LIFE INSURANCE APPLICATION (PART I) TO:

☐ **NEW YORK LIFE INSURANCE COMPANY (NYLIC)** 51 Madison Avenue, New York, NY 10010
☐ **NEW YORK LIFE INSURANCE AND ANNUITY CORPORATION (NYLIAC)** (A Delaware Corporation) 51 Madison Avenue, New York, NY 10010
☐ **NYLIFE INSURANCE COMPANY OF ARIZONA (NYLAZ) (Not Licensed in Every State)** 4343 North Scottsdale Rd., Suite 220, Scottsdale, AZ 85251

☐ New Application ☐ Attained Age Term Conversion Policy No. _____
☐ Amend Application ☐ Original Age Term Conversion
☐ Reinstatement ☐ Additional Offer Program Exercising a rider: ☐ PPO ☐ SPO ☐ SPPO
☐ Paid Change Request ☐ GIR ☐ GIR Face Increase ☐ IER

A. Primary Insured

First Name | Middle Name | Last Name | Suffix | ☐ Male ☐ Female | Date of Birth (mm/dd/yyyy)

Residence: Street | City | State | Country | Zip

☐ Social Security No. or ☐ Tax ID No. ☐ Exempt ☐ Applied for | Driver's License No. | State | ☐ None (Provide details in Section Q)

Country of Citizenship | Country of Birth | State of Birth | How Long Living in the USA? ☐ Since Birth **or** _____Years _____Months

Immigration Visa or Work Authorization *(If other than a US citizen)* Type | Number | Expiration: Month | Year | **Occupation**

Employer Name: | Street | City | State | Country | Zip

If age 18 or over, has Primary Insured used tobacco, nicotine or any nicotine substitution product in any form in the last five years? ☐ Yes ☐ No

If "Yes", provide type _____ and date of last use (Month) _____ (Year) _____

B. Contact Information

Contact Primary Insured at: *(List both and check primary)* ☐ Home Tel. Number: (_____) _____ ☐ Business Tel. Number: (____) _____

Best Time to Call: Between _____ ☐ AM ☐ PM and _____ ☐ AM ☐ PM (Please indicate widest time interval)

Time zone: ☐ EST ☐ CST ☐ MST ☐ PST ☐ AST ☐ HST Email Address: _____

Special Instructions, if any _____

In which language and dialect(s) was the sales interview conducted? Language _____ Dialect _____

Who acted as interpreter? ☐ Agent ☐ Other: | First Name | Last Name | Relationship to Primary Insured

If the Primary Insured requires special services for the hearing impaired, indicate the service required. _____

C. Owner *(if not Primary Insured)*

For all ownership types, name, address, and tax identification information is required. UTMA/UGMA requires Custodian's information to be provided.

Type: ☐ Individual ☐ Trust ☐ Corp ☐ Partnership ☐ Charitable Organization ☐ UTMA/UGMA (Provide Custodian's information below)

Owner/Custodian First Name | Middle Name | Last Name | Suffix | ☐ Male ☐ Female | Date of Birth (mm/dd/yyyy)

Residence: Street | City | State | Country | Zip

Telephone Number ( ) | Email Address | ☐ Social Security No. or ☐ Tax ID No. ☐ Exempt ☐ Applied for

Relationship to Primary Insured | Country of Citizenship

Immigration Visa or Work Authorization *(If other than a US citizen)* Type | Number | Expiration: Month | Year

Trust
Name of Trust _____ Date of Trust _____

State where Trust established _____ Name of Trustee(s) _____

Relationship of Trustee(s) to Primary Insured _____ Beneficiary(ies) of Trust _____

Relationship of Trust Beneficiary(ies) to Primary Insured _____

Uniform Transfers to Minors (UTMA/UGMA)
Name of Minor: First | Middle | Last | Suffix | Date of Birth (mm/dd/yyyy)

UTMA/UGMA for the state of | ☐ Social Security No. or ☐ Tax ID No. ☐ Exempt ☐ Applied for

PART 1 02

C. Owner *(continued)*

Successor Owner ☐ Primary Insured
First Name | Middle Name | Last Name | Suffix | Relationship to Primary Insured

Multiple Owners (Unless otherwise specified in Section Q, ownership will be joint with right of survivorship.)
First Name | Middle Name | Last Name | Suffix | Date of Birth (mm/dd/yyyy)

Residence: Street | City | State | Country | Zip

Telephone Number ( ) | Email Address | ☐ Social Security No. or ☐ Tax ID No. ☐ Exempt ☐ Applied for

Relationship to Primary Insured | Country of Citizenship

Immigration Visa or Work Authorization *(If other than a US citizen)*
Type | Number | Expiration: Month_____Year_____

D. Applicant *(if not Primary Insured)*

☐ Same as Owner

If Primary Insured is under age 18 years, complete the following questions.
Amount of in-force insurance on parent(s) or guardian(s): $_____ ☐ None
Are all other children in the family insured or to be insured for an amount at least equal to that on the Primary Insured? ☐ Yes ☐ No (If "No", provide details in Section Q)

First Name | Middle Name | Last Name | Suffix | Date of Birth (mm/dd/yyyy)

☐ Social Security No. or ☐ Tax ID No. ☐ Exempt ☐ Applied for | Relationship to Primary Insured

Residence: Street | City | State | Country | Zip

E. Payer *(if not Primary Insured)*

Same as ☐ Owner ☐ Applicant

First Name | Middle Name | Last Name | Suffix | ☐ Social Security No. or ☐ Tax ID No. ☐ Exempt ☐ Applied for

Residence: Street | City | State | Country | Zip | Relationship to Primary Insured

Relationship to Owner (if other than Primary Insured) | Date of Birth (mm/dd/yyyy)

F. Mode, Policy Date, Premium Financing, Qualified Plans, Premium Notices and Other Requests

(All modes not available on every plan or product)

For Check-O-Matic mode complete attached Check-O-Matic authorization form. For NYL-A-Plan, complete form 21237 and 21242. For Government Allotment, use form 16513.

Payment: ☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly
☐ Check-O-Matic ☐ Government Allotment ☐ NYLIFE Securities ☐ Single Sum
☐ NYL-A-Plan #_____ ☐ List Bill # _____ ☐ MainStay # _____
Chosen Policy Date _____/_____/_____ Preliminary term to _____/_____/_____ (available on WL, MPWL and CWL only)

Policy Transfers/Premium Financing

1. Does the Proposed Insured, Applicant or Owner plan to transfer any right, title, or ownership interest in the policy being applied for to a third party, or has any of these parties ever transferred any rights, title or ownership in any life insurance policy to a third party? ☐ Yes ☐ No
2. Is any part of the premium for this policy being financed by a third party, or has the Proposed Insured, Applicant or Owner been offered any inducement, fee or compensation, including "free life insurance," as an inducement to purchase life insurance? ☐ Yes ☐ No
3. Has the Proposed Insured, Applicant or Owner, within the past twelve months, authorized any third party to have a life settlement or viatical company review their personal medical status? ☐ Yes ☐ No

If "Yes" to #1, #2 or #3, provide details in Section Q.

Qualified Plans: ☐ 401(k) ☐ 401(a) ☐ 412(e)(3) ☐ Keogh ☐ 457 ☐ Pension Option ☐ _____
Other Requests: ☐ Reduced paid up at lapse ☐ Non-transfer Option
Split Dollar: ☐ Endorsement Split Dollar

Premium Notices

☐ Send Premium notice to Owner's other US address:

Street _____City _____State _____Zip _____

The Owner may designate a secondary addressee to receive notice of past due premium/potential lapse of coverage.

Name _____Street _____City _____State _____Zip _____

PART 1 03

G. Primary Insured's Beneficiary

☐ Same as Owner ☐ Family Protection Standard Beneficiary Designation (includes Additional Insured and Children)

Named Beneficiaries (indicate order as 1st, 2nd, etc.) ☐ Per Stirpes (Can only be checked if all beneficiaries are individuals)

Order	Full Name (First, Middle, Last)	Date of Birth	Social Security No./ Tax ID No.	Relationship to Primary Insured	Share

Trust

Name of Trust _____ Date of Trust _____

State where Trust established _____ Name of Trustee(s) _____

Relationship of Trustee(s) to Primary Insured _____ Beneficiary(ies) of Trust _____

Relationship of Trust Beneficiary(ies) to Primary Insured _____

Uniform Transfers to Minors (UTMA/UGMA)

Name of Custodian _____ as custodian for

Name of Minor _____ under the _____ Uniform Transfers/Gifts to Minors Act (UTMA/UGMA)

H. Current Health and Payment Information

Has the Proposed Insured or anyone proposed for coverage on the policy:

1. Within the last 90 days, been recommended by a physician or other medical practitioner to undergo diagnostic procedures or tests for any symptoms, illnesses or conditions? ☐ Yes ☐ No
2. Within the last 2 years, been unable to work or unable to attend school, or been disabled for one month or more? ☐ Yes ☐ No
3. Within the last 2 years, been admitted to a hospital or other medical facility for more than 5 consecutive days? ☐ Yes ☐ No

If "Yes" to #1, #2 or #3, do not collect deposit premium and provide name and details in Section Q.

Total amount paid $ _____ If amendment, amount previously paid $ _____

4. Complete the following questions for any Proposed Insureds actual age **24 months old or younger** (except for children under CI Rider and Family Protection Plan):

(a) Was the child born prematurely (less than 37 weeks gestation)? ☐ Yes ☐ No

(b) Was the child's birth weight less than 5 pounds (2.27 kilograms)? ☐ Yes ☐ No

(c) Has the child required hospitalization or been diagnosed with a birth injury, congenital disorder, deformity, heart murmur, developmental delay, mental retardation, or accidental injury? ☐ Yes ☐ No

If "Yes" to #4a, 4b, or 4c, provide name and details, including the name and address of physician or health care provider in Section Q.

PART 1 04

I. Coverage Information

NYLIC

	RIDERS					DIVIDEND OPTION
☐ Whole Life ☐ Custom Whole Life Premium Pay Years _____ ☐ Modified Premium Whole Life Face Amount $ _____ Premium $ _____ ☐ Automatic Premium Loan	☐ WP ☐ ADB $ _____ ☐DOT $ _____ ☐ LBR	☐ OPP ☐ COM Scheduled Bill $ _____ Unscheduled (Lump Sum) $ _____	☐ CPB ☐ CI # units _____ ☐ PPO $ _____ ☐ PPB	☐ LCTR___ PI $ _____ ☐ LCTR___ OCI 1 $ _____ ☐ LCTR___ OCI 2 $ _____	☐ YCTR PI $ _____ ☐ YCTR/OCI $ _____ ☐ _____ $ _____	(Select one) ☐ Pd Up Ad ☐ Accum ☐ Prem ☐ Cash
☐ Survivorship Whole Life Face Amount $ _____ ☐ Automatic Premium Loan	2nd to Die ☐ DOT $ _____ ☐ LTR $ _____	☐ EPR $ _____ ☐ _____	1st to Die ☐ LFD $ _____	☐ OPP/PUA ☐ COM Scheduled Bill $ _____ Unscheduled (Lump Sum) $ _____	☐ _____ $ _____	(Select one) ☐ Pd Up Ad ☐ Accum ☐ Prem ☐ Cash
☐ Yearly Convertible Term Face Amount $ _____ Premium $ _____	☐ WP ☐ ADB $ _____	☐ CI # units _____	☐ YCTR PI $ _____ ☐ YCTR/ OCI $ _____	☐ LBR ☐ PPO $ _____	☐ _____ $ _____	(Select one) ☐ Accum ☐ Prem ☐ Cash
☐ Level Premium Convertible Term _____Year Guaranteed Level Premium Face Amount $ _____	☐ WP ☐ ADB $ _____ ☐ LBR	☐ LCTR___ PI $ _____ ☐ LCTR___ OCI 1 $ _____	☐ LCTR___ OCI 2 $ _____ ☐ _____	☐ YCTR PI $ _____ ☐ YCTR/ OCI $ _____	☐ CI # units_____ ☐ ECPO (LCT 11-20 only)	☐ PPO $ _____ ☐ _____ $ _____	(Select one) ☐ Accum ☐ Prem ☐ Cash
☐ Family Protection Face Amount $ _____ (Insured 1) Face Amount $ _____ (Insured 2)	☐ WP (Insured 1) ☐ WP (Insured 2) ☐ _____	☐ LBR					(Select one) ☐ Accum ☐ Prem ☐ Cash
☐ One Year Non-Renewable Term Face Amount $ _____							(Select one) ☐ Accum ☐ Prem ☐ Cash
☐ _____ Face Amount $ _____	☐ _____ $ _____						☐ _____

NYLAZ

☐ _____ Face Amount $ _____	☐ _____ $ _____	☐ _____ $ _____

NYLIAC

	RIDERS				
☐ Universal Life ☐ ACSV IRC Sec. 7702 Option: ☐ CVAT ☐ GPT Face Amount $ _____ Life Insurance Option: ☐ Level (1) ☐ Increasing (2) ☐ Face Amount plus Adjusted Premium (3) Planned Premium $ _____ Initial Premium $ _____	☐ MDW ☐ ADB $ _____ ☐ GIR $ _____ ☐ LBR	☐ CI # units _____	☐ OCI 1 $ _____ ☐ OCI 2 $ _____	☐ NLGR ☐ _____	☐ _____ $_____ ☐ _____
☐ Survivorship Universal Life ☐ ACSV IRC Sec. 7702 Option: ☐ CVAT ☐ GPT Face Amount $ _____ Life Insurance Option: ☐ Level (1) ☐ Increasing (2) ☐ Face Amount plus Adjusted Premium (3) Planned Premium $ _____ Initial Premium $ _____	☐ FTD $ _____ ☐ EPR $ _____	☐ NLGR ☐ _____	☐ 10 YLTR $ _____		☐ _____ $_____ ☐ _____

PART 1 05

I. Coverage Information

NYLIAC	RIDERS			
☐ Custom UL Guarantee Face Amount $_____ Life Insurance Option ☐ Level ☐ _____ IRC Sec. 7702 Option ☐ CVAT ☐ _____ Planned Premium $_____ Planned Premium Paying Period_____ Addt'l 1st Year Premium $_____	☐ MDW ☐ LBR ☐ _____ $ _____	☐ _____ _____		☐ ROP Maximum ROP Benefit Amount $ _____ ROP Percentage _____% ROP Benefit Interest Rate _____%
☐ Custom SUL Guarantee Face Amount $_____ Life Insurance Option ☐ Level ☐ _____ IRC Sec. 7702 Option ☐ CVAT ☐ _____ Planned Premium $_____ Planned Premium Paying Period _____ Addt'l 1st Year Premium $_____	☐ LBR ☐ FTD $ _____ ☐ EPR $ _____ ☐ _____ $ _____	☐ 10YLTR $ _____ ☐ _____ _____		☐ ROP Maximum ROP Benefit Amount $ _____ ROP Percentage _____% ROP Benefit Interest Rate _____%
☐ Nautilus Advantage Universal Life ☐ ACSV IRC Sec. 7702 Option ☐ CVAT ☐ GPT Face Amount $_____ Life Insurance Option: ☐ Level(1) ☐ Increasing(2) ☐ Face Amount plus Adjusted Premiums (3) Planned Premium $_____ Initial Premium $_____	☐ MDW ☐ ADB $ _____ ☐ GIR $ _____ ☐ LBR	☐ CI # units _____	☐ OCI 1 $ _____ ☐ OCI 2 $ _____	☐ NLGR ☐ _____ ☐ _____ $_____ ☐ _____
☐ Nautilus Advantage Survivorship Universal Life ☐ ACSV IRC Sec. 7702 Option ☐ CVAT ☐ GPT Face Amount $_____ Life Insurance Option: ☐ Level(1) ☐ Increasing(2) ☐ Face Amount plus Adjusted Premiums (3) Planned Premium $_____ Initial Premium $_____	☐ FTD $ _____ ☐ EPR $ _____	☐ NLGR ☐ _____	☐ 10 YLTR $ _____	☐ _____ $_____ ☐ _____
☐ Instant Legacy - SPUL Single Premium $_____	Submit completed Simplified Medical Questionnaire - Part II			
☐ Variable Universal Life Accumulator IRC Sec. 7702 Option: ☐ CVAT ☐ GPT Face Amount $_____ Life Insurance Option: ☐ Level (1) ☐ Increasing (2) ☐ Face Amount plus Adjusted Premium (3) ☐ _____ Planned Premium $_____ Initial Premium $_____	☐ MDW ☐ LER ☐ GIR $ _____ ☐ LBR	☐ ADB $ _____ ☐ CI # units _____ ☐ GMDB ☐ _____ ☐ GMAB		☐ OCI 1 $ _____ ☐ OCI 2 $ _____ ☐ _____

NYLIAC	RIDERS
☐ Survivorship Variable Universal Life Accumulator IRC Sec. 7702 Option: ☐ CVAT ☐ GPT Face Amount $ _____ Life Insurance Option: ☐ Level (1) ☐ Increasing (2) ☐ Face Amount plus Adjusted Premium (3) ☐ _____ Planned Premium $ _____ Initial Premium $ _____	1st to Die ☐ FTD $ _____ ☐ EPR $ _____ ☐ GMDB (Younger Insured's Age 100) ☐ _____ ☐ LER ☐ GMAB ☐ _____ $_____
☐ Lifetime Wealth Variable Universal Life IRC Sec. 7702 Option: ☐ CVAT ☐ GPT Face Amount $ _____ Life Insurance Option: ☐ Level (1) ☐ Increasing (2) ☐ Face Amount plus Adjusted Premium (3) ☐ Planned Premium $ _____ Initial Premium $ _____ Investment Adviser ☐ None ☐ _____	☐ MDW ☐ ADB ☐ GMDB ☐ OCI 1 ☐ LER ☐ CI ☐ GMAB $ _____ $ _____ # Units_____ ☐ PAIR* ☐ OCI 2 ☐ LBR $ _____ ☐ _____ *The Pre-Approved Increased Rider (PAIR) is automatically included on all new issues, but MUST be selected for Attained Age Term Conversions
☐ Asset Preserver Face Amount $ _____ Single Premium $ _____ *Benefit Payment Option: ☐ LTC 24 ☐ LTC 36+ ☐ LTC 48+ ☐ _____	Submit completed Asset Preserver Application Supplement ☐_____ $ _____ *Not all Benefit Payment Options available in all states
☐ Single Premium Variable Universal Life Single Premium $ _____ **or** Face Amount $ _____	☐ LBR ☐_____ ☐ _____ $ _____
Executive Benefits ☐ CorpExec VUL _____ ☐ CSVUL ☐ CEUL ☐ CSUL ☐ BOLI _____ ☐ _____ IRC Sec. 7702 Option: ☐ CVAT ☐ GPT Face Amount $ _____ Life Insurance Option: ☐ Level (1) ☐ Increasing (2) ☐ Face Amount plus Adjusted Premium (3) (if applicable) ☐ _____ Planned Premium $ _____ Initial Premium $ _____ Unisex Issue: ☐ Yes ☐ No	☐ ACSV (CSUL only) ☐ LTR (CorpExec VUL only) ☐ STR (CorpExec VUL, CSVUL, CEUL, CSUL only) ☐ _____ $ _____ ☐ _____ $ _____
☐ _____ Face Amount $ _____ Planned Premium $ _____ Initial Premium $ _____ IRC Sec. 7702 Option ☐ CVAT ☐ _____ Planned Premium $_____ Planned Premium Paying Period_____ Addt'l 1st Year Premium $_____	☐_____ ☐_____ $ _____ $ _____

Alternate and Additional Policy Requests (Complete plan, face amount, rider(s), rider amount, and dividend option requests below. If changes to other sections are being requested, provide instructions below or in Section Q.)

☐ Alternate ☐ Additional

Plan:_____ Face Amount: $ _____
Rider:_____ Rider Amount: $_____
Dividend Option:_____

Instructions:_____

J. Personal Information

1. In the last 5 years, has the Primary Insured or any other Proposed Insured(s)

(a) had their driver's license suspended or revoked? ☐ Yes ☐ No

If "Yes", indicate name or maiden name (if applicable) of person(s) applying for coverage and give details below including reason, driver's license # (if other than previously stated), State of license, and month and year of occurrence.

Name	Reason	License #	State	Date (month/year)

(b) plead guilty to, or been convicted of, or been imprisoned for any felony or misdemeanor, or are there any such charges currently pending? ☐ Yes ☐ No

If "Yes", indicate name or maiden name (if applicable) of person(s) applying for coverage and give details below, including reason, State, County, and month and year of occurrence.

Name	Reason	State	County	Date (month/year)

(c) been declined for issue, reinstatement or renewal of any type of life or health insurance? ☐ Yes ☐ No

If "Yes", indicate name or maiden name (if applicable) of person(s) applying for coverage, give company name (including New York Life), reason and date.

Name	Company	Reason	Date (month/year)

2. In the next 12 months does the Primary Insured or any Proposed Insured plan to travel or reside outside the U.S. or Canada? ☐ Yes ☐ No

If "Yes", indicate name of the person(s) applying for coverage, purpose of travel (personal or business), the country, the date(s) of travel and the duration(s) of stay.

Name	Purpose	Country	Date (month/year)	Duration

3. In the last 12 months has the Primary Insured or any other Proposed Insured engaged in, or intend to engage in within the next 12 months, any of the following: ☐ Yes ☐ No

If "Yes", check all that apply and complete Form Series 7663.

☐ SCUBA or skin diving; ☐ auto racing; ☐ motorcycle racing; ☐ power boat racing; ☐ snowmobile racing; ☐ all terrain vehicle (ATV) racing; or ☐ any other type of vehicle racing; ☐ sky diving; ☐ mountain climbing; ☐ helicopter skiing; ☐ cave exploration; ☐ hot air ballooning; ☐ rodeo riding; ☐ flying as civilian pilot; ☐ flying as a military pilot; ☐ ultralight; or ☐ hang-gliding; ☐ motorcycle, snowmobile, and/or all terrain vehicle (ATV) riding? – Circle all that apply. **(Form Series 7663 is not required if leisure/non-racing only.**

Provide the following details:

Insured's Name _____ **Annual mileage** _____ **Vehicle used for** _____ **Safety helmet used? ☐ Yes ☐ No)**

K. Other Coverage *(List each Proposed Insured and details of other coverage)*

Insured's Name	None	In Force	Pending	Company	Amount	Personal	Business
	☐	☐	☐		$	☐	☐
	☐	☐	☐			☐	☐
	☐	☐	☐			☐	☐
	☐	☐	☐			☐	☐

What is the total amount of above pending coverage that will be placed in all companies for each insured? $_____

Use Section Q for Additional Details.

L. Financial Information

	Primary Insured	Other Insured	Owner if not Primary Insured
Current Annual Earned Income			
Current Annual Unearned Income			
Current Net Worth			

M. Business and Creditor Insurance

Question 1 must be completed for all Business and Creditor Insurance (except Buy/Sell). Complete Questions 2, 3 and 4, as applicable. If more space is needed, use Section Q, Additional Details.

1. **Will an employer, including a partnership, be the owner and beneficiary of the insurance applied for on the life of an employee or partner?** ☐ **Yes** ☐ **No** **("Employer" includes related parties, such as an affiliate of the business.) If "Yes", the Proposed Insured must acknowledge the following statement by initialing the space provided below.**

   I, the Proposed Insured, acknowledge and agree that: (1) my employer intends to insure my life; (2) I have been notified of the amount of insurance applied for on my life; (3) my employer will be a beneficiary of any policy proceeds payable upon my death; and (4) coverage may continue after my employment terminates.

   Proposed Insured's initials here: _____

   Notice to Owner: If "Yes" is checked above, you may be subject to IRS record keeping and annual reporting requirements relating to employer-owned life insurance contracts. Please consult with your tax advisor.

2. (a) If **BUY/SELL**, what is the net income $ _____ and market value $_____ of the business?

   (b) Does insured(s) have ownership in the business? If "Yes", list all owners and percent of ownership for each (for survivorship policy, list each insured and provide ownership percentage for each). _____ ☐ Yes ☐ No

   _____

   (c) Are all owners being insured? Provide details and amounts. _____ ☐ Yes ☐ No

   _____

3. (a) If **KEY EMPLOYEE**, provide reason why employee is key to the organization, and length of time employed.

   _____

   (b) Are all Key Employees being insured? Provide details and amounts. _____ ☐ Yes ☐ No

   _____

4. If **CREDITOR COVERAGE**, what is the loan amount $ _____, term _____ (years)_____ (months), and purpose?

   Purpose _____

   If creditor requires collateral assignment, include completed collateral assignment with application.

N. Term Conversion

Sections A, C, D, E, F, G and I of the application are also required for contractual conversions. For non-contractual conversions or changes, underwriting is required.

1. **Policy Number** _____ ☐ Term Policy ☐ Term Rider ☐ Conversion of Other Company's Term Insurance

   These term coverages can be attained age converted (AATC): ☐ OCI ☐ DOT AD105 and after ☐ TL AD 85 and prior ☐ Conversion of Spouse ☐ Conversion of Child ☐ 1YT (Div. Opt.)

   Amount to be Converted: Term Policy $ _____ **Term Rider $** _____

   Amount Remaining In Force: Term Policy $ _____ **Term Rider $** _____ (If no amount entered, remainder will be terminated)

   If there is an amount remaining in force that qualifies under the PTIS (Point in Scale) Program to be carried over to a term rider on the new base plan, are any of the following riders being applied for? ☐ New rider without underwriting (less than 5 years from original issue and meets minimum amount rules) ☐ PTIS rider without underwriting (5 years or more from original issue date or does not meet minimum amount rules) ☐ PTIS rider without underwriting (less than 5 years from original issue date and meets amount rules) ☐ New rider with underwriting required (Provide details in Section Q)

   Is a reduction in rating being requested? ☐ Yes ☐ No

   If Waiver of Premium or MDW is being applied for, does the Primary Insured have a disability which prevents him/her from being actively at work? (If "Yes", provide details and dates in Section Q.) ☐ Yes ☐ No

   If you are applying for Waiver of Premium or MDW on the Primary Insured and the existing policy **does not** include this benefit, complete Sections J and P of this application.

2. **Policy Number** _____ ☐ Term Policy ☐ Term Rider ☐ Conversion of Other Company's Term Insurance

   These term coverages can be attained age converted (AATC): ☐ OCI ☐ DOT AD105 and after ☐ TL AD 85 and prior ☐ Conversion of Spouse ☐ Conversion of Child ☐ 1YT (Div. Opt.)

   Amount to be Converted: Term Policy $ _____ **Term Rider $** _____

   Amount Remaining In Force: Term Policy $ _____ **Term Rider $** _____ (If no amount entered, remainder will be terminated)

   If there is an amount remaining in force that qualifies under the PTIS (Point in Scale) Program to be carried over to a term rider on the new base plan, are any of the following riders being applied for? ☐ New rider without underwriting (less than 5 years from original issue and meets minimum amount rules) ☐ PTIS rider without underwriting (5 years or more from original issue date or does not meet minimum amount rules) ☐ PTIS rider without underwriting (less than 5 years from original issue date and meets amount rules) ☐ New rider with underwriting required (Provide details in Section Q)

   Is a reduction in rating being requested? ☐ Yes ☐ No

   If Waiver of Premium or MDW is being applied for, does the Primary Insured have a disability which prevents him/her from being actively at work? (If "Yes", provide details and dates in Section Q.) ☐ Yes ☐ No

   If you are applying for Waiver of Premium or MDW on the Primary Insured and the existing policy **does not** include this benefit, complete Sections J and P of this application.

For Attained Age Term Conversions the following apply:

There will be no insurance in effect on the new policy prior to the policy date given in the policy or policy date specified here ____/_____/_____, and coverage on the new policy will not begin until the coverage being converted has been terminated.

I agree that any monies due from a Conversion of a NYLIC or NYLAZ policy to a NYLIC Life policy will be credited to the Dividend Option of the new life conversion policy. I agree that any monies due from a Conversion of a NYLIC or NYLAZ policy to a NYLIAC Life Policy will be credited to the Initial Premium, which will be increased to equal the credit applied to my NYLIAC policy when the credit is greater than the requested Initial Premium of the new life conversion policy.

SWL/SVUL/SUL policies pay a death benefit on the second death only, and no death benefits are payable on a first death.

The items in the Temporary Coverage Agreement and the Signature Section of this application apply even when a NYLAZ policy is being converted or when the new policy is issued by NYLIAC, a subsidiary of NYLIC.

O. Guaranteed Insurability Option Date (PPO and GIR)

Scheduled Option Date: Mo. _____ Day _____ Year_____

Date of ☐ marriage ☐ birth ☐ adoption Mo. _____ Day _____ Year_____ **Proof of event is required.**

SECTIONP 01

Do Not Complete if Any Other Type of Medical Examination Part II is Required.

P. Non-Medical Health Questionnaire

First Name Middle Name Last Name Height _____ft. _____in. Weight _____lbs.

(For each additional insured, please use a separate Additional Insured Non-Medical Health Questionnaire)

1. Primary physician or health care provider information: ☐ None Name_____
   Address _____ Phone number (_____) _____-_____
   Date of last visit: _____ /_____ /_____ Reason for visit:_____
   Treatment or medication provided: (Provide details, name and dosage) _____
2. List all prescribed medications taken on a regular basis in the last 12 months: (Include reason taken, dosage and frequency) _____
   _____
3. In the last ten (10) years, has the Proposed Insured been diagnosed, treated, tested positive for or been given medical advice by a member of the medical profession for: (If "Yes", circle all conditions that apply)
   a. Elevated blood pressure, chest discomfort, heart disorder, angina, murmur or irregular pulse? ☐ Yes ☐ No
   b. Elevated blood sugar or diabetes? ☐ Yes ☐ No
   c. Asthma, shortness of breath, chronic bronchitis (COPD), emphysema, lung disorder or any type of sleep disorder? ☐ Yes ☐ No
   d. Cancer, tumor, melanoma, leukemia, Hodgkins or any other lymphoma? ☐ Yes ☐ No
   e. Multiple sclerosis; epilepsy, seizures; mental retardation; memory loss or other neurological disorder? ☐ Yes ☐ No
   f. Pancreatitis; hepatitis; cirrhosis, liver disorder, anemia or other blood disorder? ☐ Yes ☐ No
   g. Stroke, transient ischemic attack (TIA) or other circulatory disorder? ☐ Yes ☐ No
   h. Kidney disorder; protein or blood in the urine, urinary tract disorder or elevated PSA? ☐ Yes ☐ No
   i. Colitis; blood in stool; intestinal polyps or other intestinal disorder? ☐ Yes ☐ No
   j. Muscle weakness; bone or back disorder; arthritis; lupus or other connective tissue disorder? ☐ Yes ☐ No
   k. Any psychiatric or mental health condition (include counseling or hospitalization)? ☐ Yes ☐ No
   l. Drug or alcohol use, used cocaine or other controlled substances (other than as prescribed by a physician), or been counseled or hospitalized for drug or alcohol use? ☐ Yes ☐ No
4. In the last ten (10) years, has the Proposed Insured been diagnosed by a member of the medical profession or tested positive for Human Immunodeficiency Virus (AIDS virus) or Acquired Immune Deficiency Syndrome (AIDS)? ☐ Yes ☐ No
5. In the last two (2) years, has the Proposed Insured been treated by a member of the medical profession for any of the following symptoms, for which a final medical professional diagnosis is not yet known: chest pain or pressure; blood in urine; rectal bleeding; blood in stool; loss of consciousness; recurrent shortness of breath; or cough, fever, or headache lasting five or more days? (If "Yes", circle all that apply) ☐ Yes ☐ No
6. In the last two (2) years, other than as already stated, has the Proposed Insured:
   a. Had any surgery or been recommended to have surgery? ☐ Yes ☐ No
   b. Had any diagnostic tests (excluding HIV tests) or been recommended to have any diagnostic test other than already stated? (Such as but not limited to an X-ray, CT scan, stress test, MRI or ultrasound other than for pregnancy) ☐ Yes ☐ No
   c. Been unable to work, unable to attend school or been disabled for 30 days or more? ☐ Yes ☐ No
7. Among Proposed Insured's natural parents, brothers or sisters, has anyone been diagnosed or treated by a member of the medical profession for angina, heart disorder, stroke, diabetes or cancer? (If "Yes", please provide details below, including age of parent or sibling if alive, or age and cause of death if not alive; if cancer indicated please provide type or location) ☐ Yes ☐ No
8. Has Proposed Insured lost weight in the last year? (If "Yes", please provide how many lbs. lost and reason in details below.) ☐ Yes ☐ No
9. Complete the following questions if the Proposed Insured is actual age 70 or over:
   a. Within the last 2 years, has the Proposed Insured been unable to participate in normal activities or been confined at home? ☐ Yes ☐ No
   b. Does the Proposed Insured live in a facility that provides him or her with personal care? ☐ Yes ☐ No
   c. Has the Proposed Insured been hospitalized or evaluated, counseled or treated by a member of the medical profession for memory problems or disorientation? ☐ Yes ☐ No
   d. Within the last 2 years, has the Proposed Insured had a fall resulting in a fracture, or been bed-ridden for 2 weeks or more, or has the Proposed Insured required assistance in walking, eating, bathing, toileting, or dressing? (Circle all that apply) ☐ Yes ☐ No

Give full details (including addresses and phone numbers of doctors) for all questions answered "Yes" above. If more space is needed, please use Section Q.

Ques. No.	Reason – Include diagnosis, treatment, medication, surgery and outcomes	Onset Mo. Year	Recovery Mo. Year	Doctors, Hospitals and Medical Facilities Info

Q. Additional Details

Please refer to each section letter when providing additional details and remarks.

Section

Complete only for coverage on Additional Insureds

Additional Insured

Completion of Additional Insured Non-Medical Health Questionnaire is required.

First Name | Middle Name | Last Name | Suffix | ☐ Male ☐ Female | Date of Birth (mm/dd/yyyy)

Residence: Street | City | State | Country | Zip

☐ Social Security No. or ☐ Tax ID No. ☐ Exempt ☐ Applied for | Driver's License No. State ☐ None (Provide details in Section Q) | Relationship to Primary Insured

Country of Citizenship | Country of Birth | State of Birth | How Long Living in the USA? ☐ Since Birth **or** _____Years_____Months

Immigration Visa or Work Authorization *(If other than a US citizen)* Type | Number | Expiration: Month | Year | **Occupation**

Employer Name: | Street | City | State | Country | Zip

If age 18 or over, has Proposed Insured used tobacco, nicotine or any nicotine substitution product in any form in the last five years? ☐ **Yes** ☐ **No**

If "Yes", provide type _____ and date of last use (Month) _____ (Year) _____

If Proposed Insured is under age 18 years, complete the following questions.

Amount of in-force insurance on parent(s) and guardian(s): $_____ ☐ None

Are all other children in the family insured or to be insured for an amount at least equal to that on the Proposed Insured? ☐ Yes ☐ No

(If "No", provide details in Section Q)

Named Beneficiaries ☐ Owner ☐ Primary Insured ☐ Trust ☐ UTMA/UGMA (For Trust or UTMA/UGMA, provide details in Section Q) ☐ **Per Stirpes**

Order	Full Name (First, Middle, Last)	Date of Birth	Social Security No./ Tax ID No.	Relationship to Proposed Insured	Share

Contact Information

☐ Same as for Primary Insured

Contact Additional Insured at: *(List both and check primary)* ☐ Home Tel. Number: (____) _____ ☐ Business Tel. Number: (____) _____

Best Time to Call: Between _____ ☐ AM ☐ PM and _____ ☐ AM ☐ PM (Please indicate widest time interval)

Time zone: ☐ EST ☐ CST ☐ MST ☐ PST ☐ AST ☐ HST Email Address: _____

Special Instructions, if any _____

In which language and dialect(s) was the sales interview conducted? Language_____ Dialect _____

Who acted as interpreter? ☐ Agent ☐ Other: First Name | Last Name | Relationship to Proposed Insured

If the Proposed Insured requires special services for the hearing impaired, indicate the service required._____

Children's Insurance Information (CI and Family Protection plan)

First Name	Middle Name	Last Name	☐ Male ☐ Female	Date of Birth (mm/dd/yyyy)	Relationship to Primary Insured	Social Security ☐ No. _____ ☐ Exempt ☐ Applied for

Named Beneficiaries ☐ Owner ☐ Primary Insured

Order	Full Name (First, Middle, Last)	Date of Birth	Social Security No./ Tax ID No.	Relationship to Proposed Insured	Share

1. Has any child proposed for coverage, displayed any physical or mental impairment due to illness, injury or birth defect or is any child currently taking prescribed medication on a regular basis? (If "Yes", provide details, including reason, dosage, and frequency in Section Q)..... ☐ Yes ☐ No
2. In the last 5 years, has any child proposed for coverage been hospitalized or been unable to attend school regularly? (If "Yes", provide details in Section Q).. ☐ Yes ☐ No

SECTIONP 01

Do Not Complete if Any Other Type of Medical Examination Part II is Required.

Additional Insured Non-Medical Health Questionnaire

First Name Middle Name Last Name Height _____ft. _____in. Weight _____lbs.

(For each additional insured, please use a separate Additional Insured Non-Medical Health Questionnaire)

1. Primary physician or health care provider information: ☐ None Name_____
   Address _____ Phone number (_____) _____-_____
   Date of last visit: _____ /_____ /_____ Reason for visit:_____
   Treatment or medication provided: (Provide details, name and dosage) _____
2. List all prescribed medications taken on a regular basis in the last 12 months: (Include reason taken, dosage and frequency) _____
   _____
3. In the last ten (10) years, has the Proposed Insured been diagnosed, treated, tested positive for or been given medical advice by a member of the medical profession for: (If "Yes", circle all conditions that apply)
   a. Elevated blood pressure, chest discomfort, heart disorder, angina, murmur or irregular pulse? ☐ Yes ☐ No
   b. Elevated blood sugar or diabetes? ☐ Yes ☐ No
   c. Asthma, shortness of breath, chronic bronchitis (COPD), emphysema, lung disorder or any type of sleep disorder? ☐ Yes ☐ No
   d. Cancer, tumor, melanoma, leukemia, Hodgkins or any other lymphoma? ☐ Yes ☐ No
   e. Multiple sclerosis; epilepsy, seizures; mental retardation; memory loss or other neurological disorder? ☐ Yes ☐ No
   f. Pancreatitis; hepatitis; cirrhosis, liver disorder, anemia or other blood disorder? ☐ Yes ☐ No
   g. Stroke, transient ischemic attack (TIA) or other circulatory disorder? ☐ Yes ☐ No
   h. Kidney disorder; protein or blood in the urine, urinary tract disorder or elevated PSA? ☐ Yes ☐ No
   i. Colitis; blood in stool; intestinal polyps or other intestinal disorder? ☐ Yes ☐ No
   j. Muscle weakness; bone or back disorder; arthritis; lupus or other connective tissue disorder? ☐ Yes ☐ No
   k. Any psychiatric or mental health condition (include counseling or hospitalization)? ☐ Yes ☐ No
   l. Drug or alcohol use, used cocaine or other controlled substances (other than as prescribed by a physician), or been counseled or hospitalized for drug or alcohol use? ☐ Yes ☐ No
4. In the last ten (10) years, has the Proposed Insured been diagnosed by a member of the medical profession or tested positive for Human Immunodeficiency Virus (AIDS virus) or Acquired Immune Deficiency Syndrome (AIDS)? ☐ Yes ☐ No
5. In the last two (2) years, has the Proposed Insured been treated by a member of the medical profession for any of the following symptoms, for which a final medical professional diagnosis is not yet known: chest pain or pressure; blood in urine; rectal bleeding; blood in stool; loss of consciousness; recurrent shortness of breath; or cough, fever, or headache lasting five or more days? (If "Yes", circle all that apply) ☐ Yes ☐ No
6. In the last two (2) years, other than as already stated, has the Proposed Insured:
   a. Had any surgery or been recommended to have surgery? ☐ Yes ☐ No
   b. Had any diagnostic tests (excluding HIV tests) or been recommended to have any diagnostic test other than already stated? (Such as but not limited to an X-ray, CT scan, stress test, MRI or ultrasound other than for pregnancy) ☐ Yes ☐ No
   c. Been unable to work, unable to attend school or been disabled for 30 days or more? ☐ Yes ☐ No
7. Among Proposed Insured's natural parents, brothers or sisters, has anyone been diagnosed or treated by a member of the medical profession for angina, heart disorder, stroke, diabetes or cancer? (If "Yes", please provide details below, including age of parent or sibling if alive, or age and cause of death if not alive; if cancer indicated please provide type or location) ☐ Yes ☐ No
8. Has Proposed Insured lost weight in the last year? (If "Yes", please provide how many lbs. lost and reason in details below.) ☐ Yes ☐ No
9. Complete the following questions if the Proposed Insured is actual age 70 or over:
   a. Within the last 2 years, has the Proposed Insured been unable to participate in normal activities or been confined at home? ☐ Yes ☐ No
   b. Does the Proposed Insured live in a facility that provides him or her with personal care? ☐ Yes ☐ No
   c. Has the Proposed Insured been hospitalized or evaluated, counseled or treated by a member of the medical profession for memory problems or disorientation? ☐ Yes ☐ No
   d. Within the last 2 years, has the Proposed Insured had a fall resulting in a fracture, or been bed-ridden for 2 weeks or more, or has the Proposed Insured required assistance in walking, eating, bathing, toileting, or dressing? (Circle all that apply) ☐ Yes ☐ No

Give full details (including addresses and phone numbers of doctors) for all questions answered "Yes" above. If more space is needed, please use Section Q.

Ques. No.	Reason – Include diagnosis, treatment, medication, surgery and outcomes	Onset Mo. Year	Recovery Mo. Year	Doctors, Hospitals and Medical Facilities Info

C - O - M 0 1

Check-O-Matic (C-O-M) – New Business Cases Only

1. New York Life Insurance Company, New York Life Insurance and Annuity Corporation or NYLIFE Insurance Company of Arizona, as indicated in this application, will direct the transfer of funds from the account you designate. This transfer will be used to pay premiums on the policy (policies) and/or monthly Option to Purchase Paid-up Additions (OPP) premiums. This transfer will be done each month on a regular schedule established by us. You will not receive premium notices while this arrangement is in effect.
2. This arrangement does not change the premium due dates specified in the policy and it does not extend any of the grace or late periods for paying these premiums. The policy or policies will lapse at the end of the grace or late period if the premium remains unpaid.
3. Any policy included under this arrangement is subject to our minimum and maximum premium and OPP premium rules.
4. The arrangement will apply to the policies listed below and will cover all future premiums and any current premiums that have not yet been paid.

Complete information below:

Primary Insured's Name:_____

Policy Number _____

Indicate Type:

☐ Single Check-O-Matic ☐ Check-O-Matic OPP

☐ Multiple Check-O-Matic Previous Case Reference Number or Policy Number _____

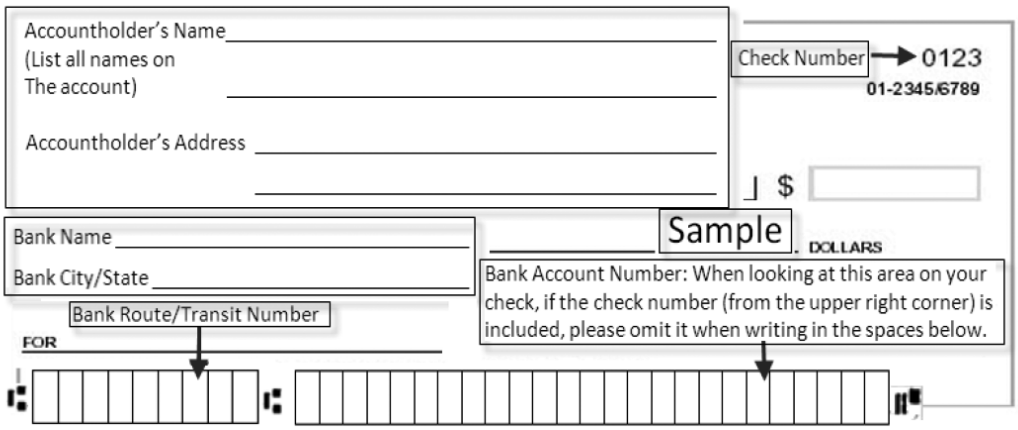
☐ Add to Check-O-Matic Previous Case Reference Number or Policy Number _____

Concurrent Insured's Name_____Date of Birth: _____/_____/_____

ELECTRONIC FUNDS TRANSFER (EFT)

☐ Check here to pay your initial premium payment via EFT. **This initial payment will be processed on or after the date the form is signed.** PLEASE NOTE: One Time EFT payments are not available for Variable Products. To have your payment(s) withdrawn directly from your bank account, via an Electronic Funds Transfer (EFT), please provide the following information or attach a VOID check/deposit slip with the following information. Please Check One: ☐ Checking Account ☐ Savings Account

IMPORTANT: Please print all information clearly.



3rd Party Payer Information

A 3rd party payer is someone other than the designated Policyowner or insured of the policy. If payment is coming from a 3rd party, the payer will need to complete the information below. **If this information is not provided, your request for the Check-O-Matic premium payment option cannot be processed.**

Name: _____ Date of Birth: _____

First Name Middle Initial Last Name

Address (Street, City, State, and Zip Code REQUIRED. **P.O. Box not acceptable**): _____

_____

Relationship to the Policyowner: _____ Social Security Number/Tax ID Number_____

Authorization Statement for Check-O-Matic (applies to Premium payments only)

I understand that I may discontinue this payment arrangement by notifying the Insurer. The Owner of each policy may discontinue it for his or her own policy. The arrangement ends on the day the Insurer receives the notice.

By initialing below I/We authorize New York Life Insurance Company or one of its subsidiaries to make monthly withdrawals from the account named above. I/We also authorize the Financial Institution named above to debit my/our account accordingly:

Initials of Depositor(s) X _____ Is the Depositor the Policyowner? ☐ Yes ☐ No

If "No", Depositor is ☐ Primary Insured ☐ Applicant ☐ Payer (Check all that apply)

PART 1 10

Statement of Agreement

Those Persons Who Sign This Application Agree That:

1. All of the statements, which are part of the application, are correctly recorded, and are complete and true to the best of the knowledge and belief of those persons who made them. Answers that are not true and complete may, subject to the policy's Incontestability Provision, invalidate coverage.
2. No agent or medical examiner has any right to accept risks, make or change contracts, or give up New York Life Insurance Company's, New York Life Insurance and Annuity Corporation's or NYLIFE Insurance Company of Arizona's rights or requirements.
3. "Cash Paid" with the application with respect to a new policy or additional benefit, provides a limited amount of temporary coverage for up to 90 days, if the terms and conditions of the Temporary Coverage Agreement are met. Temporary coverage is not provided if a policy or benefit is applied for under the terms of a conversion privilege or a guaranteed insurability option, or if reinstatement is applied for.
4. The policy date is the date from which premiums are calculated and become due. The effective date is the date the policy is delivered and the first premium is paid. Unless temporary coverage is obtained, coverage does not begin until the effective date. If the policy date is earlier than the effective date of coverage, the Policyowner pays a premium calculated beginning on that earlier policy date although coverage does not begin until the effective date.
   At the time of application, or on or before the effective date, the Applicant or Policyowner can select a policy date. The policy date may be chosen to correspond to the effective date, to obtain a lower premium rate based on a younger insurance age, because it is preferable to pay premiums on that date or have policy values accrue as of that date, or for other reasons. If no Chosen Policy Date is selected, and if no temporary coverage is obtained, the date that the policy is issued will be the policy date. It is further agreed and understood that if the policy applied for is a universal life product, interest will not be credited on the policy until the premium is received by the service office.
5. By paying premiums on a basis more frequently than annually, that is monthly, quarterly, semi-annually, NYL-A-Plan, or by Check-O-Matic, the total premium paid during one year's time will be greater than if the premium were paid once each year, or annually. In other words, the cost of paying annualized periodic payments will be more than the cost of paying one annual premium. This applies to all products issued by New York Life Insurance Company and NYLIFE Insurance Company of Arizona.
6. WARNING: The arrangement of a sale, transfer or assignment of this policy, prior to or within a period of time specified by state law after the date the policy was issued, to a third party, such as a viatical settlement entity, a life settlement entity, other secondary market provider or premium financing entity, may violate the law of your state of residence. If there are any questions pertaining to these matters please consult with your legal advisor.

Fraud Warnings:

FOR ARKANSAS: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

FOR DISTRICT OF COLUMBIA: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Illustration

Do not complete this section if:
1. A signed illustration is not required by law; or 2. An illustration was signed and matches the policy applied for.

I, the Applicant, did not sign an illustration because:

☐ An illustration was not shown or given to me.

☐ An illustration was shown or given to me, but the policy applied for is different from the illustration.

☐ An illustration was displayed to me on a screen. The displayed illustration matches the policy applied for, but no printed copy of the illustration was furnished. The illustration on the screen included the following personal and policy information:

Type of Policy _____ Proposed Insured _____

Initial Death Benefit _____ Rating/Class _____

Dividend Option _____ Age _____ Sex _____

I acknowledge that I did not sign an illustration for the reason stated above and I understand that an illustration matching the policy as issued will be provided for signature no later than at the time the policy is delivered.

PART 1 1 1

Tax Certification

Under penalties of perjury, I (as the Owner named in Section A or C) certify that: (1) the Social Security or Employer ID Number shown in this application is my correct taxpayer identification number, or I am awaiting a number to be issued to me (noted as "applied for" in Section A or C) AND (2) I am not subject to backup withholding because: (a) I am exempt from backup withholding; or (b) I have not been notified by the IRS that I am subject to backup withholding as a result of a failure to report all interest or dividends; or (c) the IRS has notified me that I am no longer subject to backup withholding (Cross out item 2 if the IRS has notified you that you are subject to backup withholding.) and (3) I am a U.S. person (including a U.S. resident alien).

ACKNOWLEDGEMENT

I, the Proposed Insured, have been given a copy of "Information Practices Related to Underwriting Your Application" which tells how New York Life Insurance Company, New York Life Insurance and Annuity Corporation and NYLIFE Insurance Company of Arizona obtain and use data about me. It includes the notice required by the State and Federal Fair Credit Reporting Acts and a description of MIB, Inc. (Medical Information Bureau). I know that my application cannot be processed if I do not sign the Authorization below.

AUTHORIZATION

In this Authorization, "I", "my" and "me" mean the Proposed Insured, "the Insurer" means New York Life Insurance Company, New York Life Insurance and Annuity Corporation, and NYLIFE Insurance Company of Arizona and their respective agents, employees, and representatives. In order to see if (and on what basis) I qualify for the insurance applied for or any other insurance offered by any of the insurers identified above, I authorize the following:

MEDICAL INFORMATION: Physicians or practitioners; hospitals; medical or medically related facilities; pharmacies, pharmacy benefit managers or medical information retrieval services; laboratories; insurance companies; or MIB may give to the Insurer (or any consumer reporting agency acting on its behalf) and to any of its reinsurers, at my request, copies of the record or other data that they may have about my physical and mental health, and my prescription drug history. This includes all protected health information and any health information I have previously requested be withheld from further disclosure, and including my history, their findings, diagnoses and treatment. Mental health professionals may provide their records of my diagnosis, functional status, treatment plan, symptoms, prognosis, progress to date, medication prescription and monitoring, and clinical test results.

OTHER UNDERWRITING INFORMATION MIB, other insurance companies and consumer reporting agencies may give to the Insurer and to any of its reinsurers data about: my driving record; any criminal activity or association; hazardous sport or aviation activity; use of alcohol or drugs; any claim of eligibility for disability income benefits; and other applications for life insurance.

EXAMINATIONS AND TESTS The Insurer may obtain physical examinations or medical tests deemed necessary to underwrite my application. These tests (where permitted by law) may include, but are not limited to, electrocardiograms, chest x-rays and tests of blood and urine to determine, among other things, exposure to causative agents of disease (for example, exposure to the AIDS virus) and the presence of drugs. However, a separate notification/authorization form will be provided with respect to testing for the AIDS virus.

INVESTIGATIVE CONSUMER REPORT The Insurer may obtain an investigative consumer report and may give the consumer reporting agency information concerning the amount and type of my coverage and my use, if any, of tobacco. The report may add to or confirm the types of data mentioned above. It may also contain data about: my identity; age; residence; marital status; past and present jobs (including work duties); economic conditions; driving record; personal and business reputation in the community; and mode of living; but will not include any information relating directly or indirectly to sexual orientation.

IDENTIFICATION To obtain the data described above, the Insurer may give my name, address, and date and place of birth to the above persons or organization.

RELEASE OF INFORMATION TO OTHERS When necessary, the Insurer may give data about me that affects my insurability to: its subsidiaries; its affiliates; its parent company; its agents and their staffs; its reinsurers; and the Insurer and its reinsurers may give such data to MIB. However, this will not be done in connection with information relating to the AIDS virus.

I also authorize the release of these same types of data about any of my children who are to be insured. This Authorization may be used for a period of 24 months from the date signed below unless sooner revoked. I may revoke this Authorization at anytime by notifying the Insurer in writing. This revocation will not be effective to the extent the Insurer or any other person already has disclosed or collected information or taken other action in reliance on it. The information the Insurer obtains through this Authorization may become subject to further disclosure. For example, the Insurer may be required to provide it to an insurance regulatory or other government agency. In this case, the information may no longer be protected by the rules governing this Authorization. A photocopy of this Authorization and request form shall be as valid as the original. I know that I may request a copy of this Authorization. (Please provide a copy to me. _____ initial if requested).

The Internal Revenue Service Does Not Require Your Consent To Any Provision Of This Document Other Than The Certifications Required To Avoid Backup Withholding.

Signatures

By signing below, I/We understand that I/We acknowledge and agree to all of the statements and representations made in this application, including sections entitled Business and Creditor Insurance (if applicable), Statement of Agreement, Illustration (if applicable), Check-O-Matic (if applicable), Tax Certification, Acknowledgement and Authorization. I/We accept and adopt as true all statements made by the Proposed Insured(s) in this application.

X _____ Signed at _____ On _____
Signature of the Primary Insured (Parent or Guardian if under 14 years 6 months) (City, State) (MM/DD/YYYY)

X _____ _____
Signature of the Owner if Other than the Primary Insured Title if signed on behalf of Corporation, Trust, etc.

X _____ X _____
Signature of Applicant if Other than Primary Insured or Owner Signature of Other Insured

X _____ X _____
Signature of Other Insured Signature of Other Insured

X _____
Other Required Signature

I Certify I have truly and accurately recorded all answers given to me.

X _____ X _____
Signature of Agent/Witness Countersigned by Licensed Resident Agent *(if required)*

X _____ _____
Signature of Agent/Witness Countersigned Code #

NON 01

☐ **NEW YORK LIFE INSURANCE COMPANY (NYLIC)** 51 Madison Avenue, New York, NY 10010
☐ **NEW YORK LIFE INSURANCE AND ANNUITY CORPORATION (NYLIAC)** (A Delaware Corporation) 51 Madison Avenue, New York, NY 10010
☐ **NYLIFE INSURANCE COMPANY OF ARIZONA (NYLAZ) (Not Licensed in Every State)** 4343 North Scottsdale Rd., Suite 220, Scottsdale, AZ 85251

Medical Questionnaire (Non-Medical – Application Part II)

First Name Middle Name Last Name	☐ Male ☐ Female	Date of Birth (mm/dd/yyyy)	Height ____ft. ____in. Weight _____lbs.
☐ Social Security No. or ☐ Tax ID No. ☐ Exempt ☐ Applied for		Policy No./Tracking No.	

1. Primary physician or health care provider information: ☐ None Name_____
   Address _____ Phone number (_____) _____-_____
   Date of last visit: _____ /_____ /_____ Reason for visit:_____
   Treatment or medication provided: (Provide details, name and dosage) _____
2. List all prescribed medications taken on a regular basis in the last 12 months: (Include reason taken, dosage and frequency) _____
   _____
3. In the last ten (10) years, has the Proposed Insured been diagnosed, treated, tested positive for or been given medical advice by a member of the medical profession for: (If "Yes", circle all conditions that apply)
   a. Elevated blood pressure, chest discomfort, heart disorder, angina, murmur or irregular pulse? ☐ Yes ☐ No
   b. Elevated blood sugar or diabetes? ☐ Yes ☐ No
   c. Asthma, shortness of breath, chronic bronchitis (COPD), emphysema, lung disorder or any type of sleep disorder? ☐ Yes ☐ No
   d. Cancer, tumor, melanoma, leukemia, Hodgkins or any other lymphoma? ☐ Yes ☐ No
   e. Multiple sclerosis; epilepsy, seizures; mental retardation; memory loss or other neurological disorder? ☐ Yes ☐ No
   f. Pancreatitis; hepatitis; cirrhosis, liver disorder, anemia or other blood disorder? ☐ Yes ☐ No
   g. Stroke, transient ischemic attack (TIA) or other circulatory disorder? ☐ Yes ☐ No
   h. Kidney disorder; protein or blood in the urine, urinary tract disorder or elevated PSA? ☐ Yes ☐ No
   i. Colitis; blood in stool; intestinal polyps or other intestinal disorder? ☐ Yes ☐ No
   j. Muscle weakness; bone or back disorder; arthritis; lupus or other connective tissue disorder? ☐ Yes ☐ No
   k. Any psychiatric or mental health condition (include counseling or hospitalization)? ☐ Yes ☐ No
   l. Drug or alcohol use, used cocaine or other controlled substances (other than as prescribed by a physician), or been counseled or hospitalized for drug or alcohol use? ☐ Yes ☐ No
4. In the last ten (10) years, has the Proposed Insured been diagnosed by a member of the medical profession or tested positive for Human Immunodeficiency Virus (AIDS virus) or Acquired Immune Deficiency Syndrome (AIDS)? ☐ Yes ☐ No
5. In the last two (2) years, has the Proposed Insured been treated by a member of the medical profession for any of the following symptoms, for which a final medical professional diagnosis is not yet known: chest pain or pressure; blood in urine; rectal bleeding; blood in stool; loss of consciousness; recurrent shortness of breath; or cough, fever, or headache lasting five or more days? (If "Yes", circle all that apply) ☐ Yes ☐ No
6. In the last two (2) years, other than as already stated, has the Proposed Insured:
   a. Had any surgery or been recommended to have surgery? ☐ Yes ☐ No
   b. Had any diagnostic tests (excluding HIV tests) or been recommended to have any diagnostic test other than already stated? (Such as but not limited to an X-ray, CT scan, stress test, MRI or ultrasound other than for pregnancy) ☐ Yes ☐ No
   c. Been unable to work, unable to attend school or been disabled for 30 days or more? ☐ Yes ☐ No
7. Among Proposed Insured's natural parents, brothers or sisters, has anyone been diagnosed or treated by a member of the medical profession for angina, heart disorder, stroke, diabetes or cancer? (If "Yes", please provide details below, including age of parent or sibling if alive, or age and cause of death if not alive; if cancer indicated please provide type or location) ☐ Yes ☐ No
8. Has Proposed Insured lost weight in the last year? (If "Yes", please provide how many lbs. lost and reason in details below.). ☐ Yes ☐ No
9. Complete the following questions if the Proposed Insured is actual age 70 or over:
   a. Within the last 2 years, has the Proposed Insured been unable to participate in normal activities or been confined at home? ☐ Yes ☐ No
   b. Does the Proposed Insured live in a facility that provides him or her with personal care? ☐ Yes ☐ No
   c. Has the Proposed Insured been hospitalized or evaluated, counseled or treated by a member of the medical profession for memory problems or disorientation? ☐ Yes ☐ No
   d. Within the last 2 years, has the Proposed Insured had a fall resulting in a fracture, or been bed-ridden for 2 weeks or more, or has the Proposed Insured required assistance in walking, eating, bathing, toileting, or dressing? (Circle all that apply) ☐ Yes ☐ No

Give full details (including addresses and phone numbers of doctors) for all questions answered "Yes" above. If more space is needed, please use another form.

Ques. No.	Reason – Include diagnosis, treatment, medication, surgery and outcomes	Onset Mo. Year	Recovery Mo. Year	Doctors, Hospitals and Medical Facilities Info

By SIGNING BELOW, I/WE DECLARE THAT, to the best of my/our knowledge and belief, all the answers given in this Part II are correctly recorded, complete and true. I/We also understand that the Insurer will rely upon the answers in this Part II in determining if (and on what basis) life insurance may be issued on the life of the person proposed for coverage, and that this Part II will be attached to and made part of any such life insurance policy.

Dated at _____ on _____ /_____ /_____
(City, State) (mm/dd/yyyy)

_____
Signature of Person Proposed for Coverage

_____
Signature of Parent or Guardian, if person examined is under age 14 years and 6 months

Witnessed by_____

MEDEXAM 01

☐ **NEW YORK LIFE INSURANCE COMPANY (NYLIC)** 51 Madison Avenue, New York, NY 10010
☐ **NEW YORK LIFE INSURANCE AND ANNUITY CORPORATION (NYLIAC)** (A Delaware Corporation) 51 Madison Avenue, New York, NY 10010
☐ **NYLIFE INSURANCE COMPANY OF ARIZONA (NYLAZ) (Not Licensed in Every State)** 4343 North Scottsdale Rd., Suite 220, Scottsdale, AZ 85251

Medical Examiner's Report – Application Part II

First Name	Middle Name	Last Name	☐ Male ☐ Female	Date of Birth (mm/dd/yyyy)

☐ Social Security No. or ☐ Tax ID No. ☐ Exempt ☐ Applied for	Policy No./Tracking No.

1. Primary physician or health care provider information: ☐ None Name _____

Address _____ Phone number (_____) _____-_____

Date of last visit: _____ /_____ /_____ Reason for visit: _____

Treatment or medication provided: (Provide details, name and dosage) _____

2. List all prescribed medications taken on a regular basis in the last 12 months: (Include reason taken, dosage and frequency) _____

_____

3. In the last ten (10) years, has the Proposed Insured been diagnosed, treated, tested positive for or been given medical advice by a member of the medical profession for: (If "Yes", circle all conditions that apply)
   a. Elevated blood pressure, chest discomfort, heart disorder, angina, murmur or irregular pulse? ☐ Yes ☐ No
   b. Elevated blood sugar or diabetes? ☐ Yes ☐ No
   c. Asthma, shortness of breath, chronic bronchitis (COPD), emphysema, lung disorder or any type of sleep disorder? ☐ Yes ☐ No
   d. Cancer, tumor, melanoma, leukemia, Hodgkins or any other lymphoma? ☐ Yes ☐ No
   e. Multiple sclerosis; epilepsy, seizures; mental retardation; memory loss or other neurological disorder? ☐ Yes ☐ No
   f. Pancreatitis; hepatitis; cirrhosis, liver disorder, anemia or other blood disorder? ☐ Yes ☐ No
   g. Stroke, transient ischemic attack (TIA) or other circulatory disorder? ☐ Yes ☐ No
   h. Kidney disorder; protein or blood in the urine, urinary tract disorder or elevated PSA? ☐ Yes ☐ No
   i. Colitis; blood in stool; intestinal polyps or other intestinal disorder? ☐ Yes ☐ No
   j. Muscle weakness; bone or back disorder; arthritis; lupus or other connective tissue disorder? ☐ Yes ☐ No
   k. Any psychiatric or mental health condition (include counseling or hospitalization)? ☐ Yes ☐ No
   l. Drug or alcohol use, used cocaine or other controlled substances (other than as prescribed by a physician), or been counseled or hospitalized for drug or alcohol use? ☐ Yes ☐ No
4. In the last ten (10) years, has the Proposed Insured been diagnosed by a member of the medical profession or tested positive for Human Immunodeficiency Virus (AIDS virus) or Acquired Immune Deficiency Syndrome (AIDS)? ☐ Yes ☐ No
5. In the last two (2) years, has the Proposed Insured been treated by a member of the medical profession for any of the following symptoms, for which a final medical professional diagnosis is not yet known: chest pain or pressure; blood in urine; rectal bleeding; blood in stool; loss of consciousness; recurrent shortness of breath; or cough, fever, or headache lasting five or more days? (If "Yes", circle all that apply) ☐ Yes ☐ No
6. In the last two (2) years, other than as already stated, has the Proposed Insured:
   a. Had any surgery or been recommended to have surgery? ☐ Yes ☐ No
   b. Had any diagnostic tests (excluding HIV tests) or been recommended to have any diagnostic test other than already stated? (Such as but not limited to an X-ray, CT scan, stress test, MRI or ultrasound other than for pregnancy) ☐ Yes ☐ No
   c. Been unable to work, unable to attend school or been disabled for 30 days or more? ☐ Yes ☐ No
7. Among Proposed Insured's natural parents, brothers or sisters, has anyone been diagnosed or treated by a member of the medical profession for angina, heart disorder, stroke, diabetes or cancer? (If "Yes", please provide details below, including age of parent or sibling if alive, or age and cause of death if not alive; if cancer indicated please provide type or location) ☐ Yes ☐ No
8. Has Proposed Insured lost weight in the last year? (If "Yes", please provide how many lbs. lost and reason in details on Page 2.) ☐ Yes ☐ No
9. Complete the following questions if the Proposed Insured is actual age 70 or over:
   a. Within the last 2 years, has the Proposed Insured been unable to participate in normal activities or been confined at home? ☐ Yes ☐ No
   b. Does the Proposed Insured live in a facility that provides him or her with personal care? ☐ Yes ☐ No
   c. Has the Proposed Insured been hospitalized or evaluated, counseled or treated by a member of the medical profession for memory problems or disorientation? ☐ Yes ☐ No
   d. Within the last 2 years, has the Proposed Insured had a fall resulting in a fracture, or been bed-ridden for 2 weeks or more, or has the Proposed Insured required assistance in walking, eating, bathing, toileting, or dressing? (Circle all that apply) ☐ Yes ☐ No

Give full details on Page 2 for all questions answered "Yes" above.

MEDEXAM 02

First Name Middle Name Last Name

Give full details (including addresses and phone numbers of doctors) for all questions answered "Yes" on Page 1. If more space is needed, please use another form.

Ques. No.	Reason – Include diagnosis, treatment, medication, surgery and outcomes	Onset Mo. Year	Recovery Mo. Year	Doctors, Hospitals and Medical Facilities Info

By SIGNING BELOW, I/WE DECLARE THAT, to the best of my/our knowledge and belief, all the answers given in this Part II are correctly recorded, complete and true. I/We also understand that the Insurer will rely upon the answers in this Part II in determining if (and on what basis) life insurance may be issued on the life of the person examined, and that this Part II will be attached to and made part of any such life insurance policy.

Dated at_____ on _____ /_____ /_____ _____
(City, State) (mm/dd/yyyy) Signature of person examined

_____ Witnessed by_____
Signature of Parent or Guardian, if person examined is under age 14 years and 6 months

MEDEXAM 03

Examiner's Report – Not Part of the Application

Agent Name _____
G.O. Code _____ *Agent Code* _____

First Name Middle Name Last Name

10. Height _____ft. _____in. Weight _____lbs.

11. **Blood Pressure.** Take a second reading at the end of the examination. Report all observations. (Do not complete if examinee is under age 12.)

	1st reading	2nd reading
Systolic	_____ mm.	_____ mm.
Diastolic	_____ mm.	_____ mm.

12. **Pulse.** (Do not report if examinee is under age 12.)

Pulse rate at rest _____ Per/Min.

Any pulse irregularity? ☐ Yes ☐ No
(If "Yes", obtain EKG and provide details below)

13. Did you measure the height of the examinee? ☐ Yes ☐ No
If "No", provide details below.

14. Did you weigh the examinee? ☐ Yes ☐ No
If "No", provide details below.

15. Did you observe any indication of physical or mental impairment not indicated on the medical form? (If "Yes", provide details below) ☐ Yes ☐ No

16. Are you related to the person examined or has the person ever consulted you for any reason other than an insurance examination? (If "Yes", provide details below) ☐ Yes ☐ No

17. Did the person examined communicate in English well enough to understand and answer the questions on the medical form? ☐ Yes ☐ No
If "No", who acted as interpreter? ☐ Examiner ☐ Agent ☐ Other (Name and relationship to insured. The owner or beneficiary of this insurance may not act as interpreter. A disinterested party must be used.) _____

Urinalysis is required except if examinee is under Age 12. All urine specimens are to be sent to lab for analysis.

COMPLETE THIS SECTION *ONLY* FOR A FULL MEDICAL EXAM.

18. **Cardiovascular Examination.**

a. Is there any evidence of cardiovascular disease excluding murmur? (If "Yes", provide details below) ☐ Yes ☐ No

b. Is a murmur present? (If "Yes", complete this section.) ☐ Yes ☐ No

Timing: ☐ Systolic ☐ Presystolic ☐ Diastolic

Location: ☐ Apex ☐ Aortic ☐ Pulmonic ☐ Other _____

Transmission: ☐ Axilla ☐ Neck ☐ Precordium ☐ None ☐ Other _____

Intensity: ☐ Soft (Gr. 1-2) ☐ Moderate (Gr. 3-4) ☐ Loud (Gr. 5-6)

Impression: _____

19. **Comments or Details to answers above:**

Ques. No.	Comments or Details
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

I CERTIFY that I have carefully examined the person named above and not in the presence of any other person except as stated in the comments section, that I have asked each question exactly as set forth on Page 1 and that the answers thereto are exactly as made to me, and that they have been signed in my presence. I have also reviewed all answers on this page and Page 1 and 2, and believe them to be correctly recorded, complete and true.

Please print your name _____ Signature _____

Name of examining company _____ Date _____ /_____ /_____

Please stamp / provide Social Security No. or Tax ID No. and address. SS # or TIN # _____

Address: Street _____ City _____

State _____ Zip _____ Country _____

TO THE EXAMINER: Any erasures or alterations in this report should be initialed by you. A copy of "answers to the Examiner" (Page 1 and 2) is included in any policy issued; the "examiner's report" (this page) is not included in the policy. If you have any information included above or not shown on this form which you believe should be seen only by Underwriting personnel, please send this report and any confidential information directly to Life Medical Underwriting, New York Life, 51 Madison Avenue, New York, NY 10010.

SERFF Tracking Number:	*NYLC-127311493*	*State:*	*Arkansas*
Filing Company:	*New York Life Insurance Company*	*State Tracking Number:*	*49245*
Company Tracking Number:	*211-500, ET AL.*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*2011 NB21 Applications*		
Project Name/Number:	*2011 NB21 Applications /211-500, et al.*		

Supporting Document Schedules

Item Status: **Status Date:**

Satisfied - Item: Flesch Certification
Comments:
Attachment:
NYLIC Readability Cert.pdf

Item Status: **Status Date:**

Bypassed - Item: Application
Bypass Reason: N/A
Comments:

NEW YORK LIFE INSURANCE AND ANNUITY CORPORATION

READABILITY CERTIFICATION

I certify that the forms listed on the attached page(s) meet the standards of your State's Readability Laws.

New York Life Insurance Company

Signature

Linda E. LoPinto
Name

Corporate Vice President
Title

July 7, 2011
Date

New York Life Insurance Company

Flesch Scores for forms submitted with this filing are:

Form No.	Flesch Score
209-500	51
209-510	68
209-525	71